AN ACT REQUIRING HEALTH INSURERS TO DISCLOSE PREAUTHORIZATION OR PREAPPROVAL REQUIREMENTS AND ESTIMATED COVERED AND OUT-OF-POCKET COSTS FOR CERTAIN HEALTH CARE SERVICES; AMENDING SECTIONS 33-22-244 AND 33-22-521, MCA; AND PROVIDING A DELAYED EFFECTIVE DATE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-244, MCA, is amended to read:

"33-22-244. Disclosure standards -- individual policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, an individual disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

(f) a description of any preauthorization or other preapproval requirements for medical care;

~~(f)~~(g) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer; and

~~(g)~~(h) a general description of the trend of premium increases or decreases for comparable policies

issued by the insurer during the preceding 5 years, if the trend data is available.

(3) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate individual disability policy.

(4) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(5) Prior to issuance of an individual disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a potential applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

Section 2. Section 33-22-521, MCA, is amended to read:

"33-22-521. Disclosure standards -- group policy. (1) In order to provide for full and fair disclosure in the sale of disability insurance, a group disability insurance policy may not be delivered or issued for delivery in this state unless an outline of coverage is filed with and approved by the insurance commissioner in accordance with 33-1-501 and is delivered to the applicant at the time the application is made.

(2) The outline of coverage must include:

(a) a general description of the principal benefits and coverages provided by the policy;

(b) a general description of the insured's financial responsibility under the policy, including, if applicable, the amount of the deductible, the amount or percentage of copayment, and the maximum annual out-of-pocket expenses to be paid by the insured;

(c) a statement of the maximum lifetime benefit available under the policy;

(d) a statement of the estimated periodic premium to be paid by the insured;

(e) a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant;

(f) a description of any preauthorization or other preapproval requirements for medical care;

~~(f)~~(g) a prominently displayed statement of the insured's responsibility for payment of billed charges beyond those charges reimbursed by the insurer when the insured uses health care services from a health care provider who is outside a network of health care providers used by the insurer; and

~~(g)~~(h) a general description of the trend of premium increases or decreases for comparable policies

issued by the insurer during the preceding 5 years, if the trend data is available.

(3) If applicable, the outline of coverage must disclose that the policy does not contain coverage for mental illness or chemical dependency.

(4) The outline of coverage may include any other information that the insurer considers relevant to the applicant's selection of an appropriate group disability policy.

(5) An insurer or producer shall provide to an individual, upon request, an outline of coverage for any health benefit product marketed to the general public. The outline of coverage provided under this subsection may exclude the statement of the estimated periodic premium to be paid by the insured.

(6) An outline of coverage must also be sent to an employee when an employee is sent a certificate of insurance.

(7) Prior to issuance of a group disability insurance policy, written informational materials describing the policy's cancer screening coverages must be provided to a prospective applicant. The informational materials are not subject to filing with and approval of the insurance commissioner."

Section 3. Short title. [Sections 3 through 5] may be cited as the "Patient's Right to Know of Insurance Coverage Provisions Act".

Section 4. Legislative purpose. The purpose of [sections 3 through 5] is:

(1) to provide health care consumers with better information regarding the portion of their health care costs that will be paid by their health insurer and the portion that they will have to pay themselves; and

(2) to introduce elements of competition into the marketplace.

Section 5. Disclosures required of health insurers -- limitations. (1) When requested by an insured or the insured's agent, a health insurer shall provide a summary of the insured's coverage for a specific health care service or course of treatment when an actual charge or estimate of charges by a health care provider, outpatient center for surgical services, clinic, or hospital exceeds $500.

(2) The insured or insured's agent may request that the information required under this section be provided in writing or electronically.

(3) The health insurer shall make a good faith effort to provide accurate information under this section.

The health insurer is only required to provide information under this section based upon cost estimates and procedure codes obtained by the insured from the insured's health care provider.

Section 6. Codification instruction. [Sections 3 through 5] are intended to be codified as an integral part of Title 50, chapter 4, part 5, and the provisions of Title 50, chapter 4, part 5, apply to [sections 3 through 5].

Section 7. Effective date. [This act] is effective January 1, 2010.

- END -

I hereby certify that the within bill,

HB 0264, originated in the House.

Chief Clerk of the House

Speaker of the House

Signed this _____ day

of _____, 2009.

President of the Senate

Signed this _____ day

of _____, 2009.

HOUSE BILL NO. 264

INTRODUCED BY C. SMITH

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